2009

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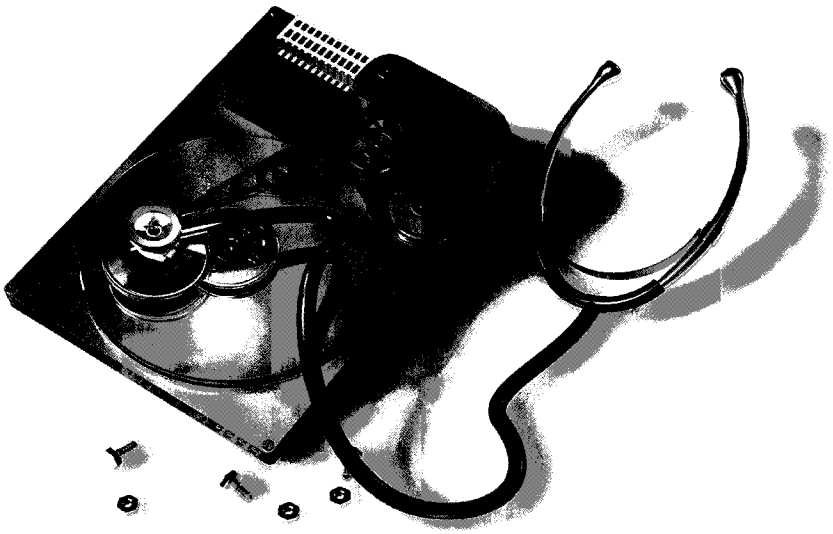
HealthShare Montana



Legislature Information Packet

1/28/2009

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HealthShare Montana Board

Member	Position
* Kristin Juliar	Chair
*Dwight Hiesterman	Vice-Chair
*Greg Drapes	Secretary
*Keith Wolcott	Treasurer
*Mike Foster	Legislative Workgroup
*Chris Stevens	Technology Workgroup
*Mike Schweitzer, MD	Clinical Workgroup
*Jan VanRiper	Privacy and Security Workgroup

Member	Title	Affiliation
Lil Anderson	CEO/Health Officer	Yellowstone City/County Health Department/Deering Community Health Center
Tanya Ask	VP of Government Affairs	BC/BS
Jan VanRiper	Consultant	East Carolina University
Gail Briese-Zimmer	Administrator, Office of Planning, Coordination & Analysis	Department of Health and Human Services
Dick Clark	CIO	State of Montana Information Technology Services Division
Candy Deruchia	Director of Information Services	Kalispell Regional Medical Center
Greg Drapes	CEO	Monida Healthcare Network
Mike Foster	Regional Director of Advocacy	St. Vincent Healthcare
Dwight Hiesterman, MD	Clinical Consultant	Mountain-Pacific Quality Health
Kristin Juliar	Director	Montana Office of Rural Health/AHEC
Jack King	Executive Director	Northcentral Montana Healthcare Alliance
Steve McNeece	CEO	Community Hospital of Anaconda
Bob Olsen	Vice President	Montana Hospital Association
William Reiter, MD	Chief Medical Officer	Community Hospital of Anaconda
Mike Schweitzer, MD	Medical Director, Peri-operative Services	St. Vincent Healthcare
David Kibbe, MD	Senior Advisor	American Academy of Family Physicians
Chris Stevens	Vice President and CIO	Billings Clinic
Kami Syvertson	Information Systems Analyst	Bozeman Deaconess Hospital
Cherie Taylor	CEO	Northern Rockies Medical Center
Mark Wakai	CEO	Rocky Mountain Health Network
G. Brian Zins	Exec. Vice President and CEO	Montana Medical Association

Current Stakeholders

- BC/BS - Blue Cross/Blue Shield
- Benefis Healthcare
- Big Horn Hospital Association
- Billings Clinic
- Bozeman Deaconess Hospital
- Community Hospital of Anaconda
- Community Medical Center of Missoula
- DPHHS - Department of Public Health and Human Services
- Employee Benefit Management Services, Inc.
- Fallon Medical Complex
- Glacier Community Health Center
- Great Falls Clinic
- HealthCenter Northwest
- Heath-e-Web
- Holy Rosary Healthcare
- InfoMine of the Rockies, Inc.
- Ingenium Data Technics, Inc.
- Kalispell Regional Medical Center
- MAHCP (Montana Association of Healthcare Purchasers)
- Marcus Daly Memorial Hospital
- Marias Medical Center
- MHA - Montana Hospital Association
- MHREF - Montana Health Research and Education Foundation
- MMA - Montana Medical Association
- Monida Healthcare Network
- Montana Frontier Healthcare Network
- Montana Mental Health
- Montana Office of Rural Health and Montana Area Health Education Center
- Montana State Auditor's Office
- Mountain-Pacific Quality Health
- Mount Powell Medical Society
- MPCA - Montana Primary Care Association
- MT Tech – Healthcare Informatics Degree Program
- MT Tech – National Center for Healthcare Informatics
- New West Health Services
- North Valley Hospital
- Northcentral Montana Healthcare Alliance
- Northern Montana Hospital
- Northern Rockies Medical Center
- Northwest EHR Collaborative, Inc.
- Office of U.S. Senator Max Baucus
- Pondera Medical Center

- Powell County Medical Center
- Rocky Mountain Health Network
- Statewide Healthcare Coalition
- St. James Healthcare
- St. Joseph Hospital
- St. John's Lutheran Hospital
- St. Luke Community Healthcare
- St. Patrick Hospital & Health Sciences Center
- St. Peter's Hospital
- St. Vincent Healthcare
- Synesis 7
- Western Montana Clinic
- Yellowstone City-County Health Department

HeatlhShare Montana

Financial Contributions for Start-Up Operations

January, 2009

MT Medical Association on behalf of Mt Powell Medical Society	**$ 500**
Community Hospital of Anaconda	**$ 1,000**
Blue Cross/Blue Shield	**$20,000**
St.Vincent's/Sisters of Charity	**$10,000**
Billings Clinic	**$10,000**
Rocky Mountain Health Network	**$10,000**
Allegiance	**$ 2,500**
Monida	**$ 4,000**
New West Health Services	**$ 5,000**
Montana Office of Rural Health	**$ 500**

TOTAL: **$63,000**

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United States Senate

WASHINGTON, DC 20510-2602

December 19, 2008

Hello Friends,

I'm sorry I can't be with you in person. I'd like to thank Cleary Waldren, all the HealthShare Montana stakeholders and the folks at Community Hospital of Anaconda for sharing my commitment to keeping Montanans healthy.

HealthShare Montana is doing a tremendous job- working to ensure Montanans get the top quality care they deserve. I'm so proud of the work you have done and are continuing to do. Please keep up the good work!

Like the folks in this room, I strongly believe every Montanan deserves access to quality affordable health care. As chairman of the Senate Finance Committee, I'm leading the charge for health care reform. Establishing HSM was just a first step. Last month, I issued a "Call to Action," which laid out my plan for health care reform. It's a blueprint that will provide universal health coverage, reduce health care costs and improve health care quality. My plan includes implementing a technology based medical records system would streamline the health care application process.

We must find solutions to our health care crisis and by working together. HealthShare Montana is a perfect example of the value of cooperation. Together, I'm confident we will make great strides in health care reform.

I'd like to wish you each a peaceful and happy holiday season and wonderful new year!

All the best,

BILLINGS (406) 657-6790
BOZEMAN (406) 586-6104
BUTTE (406) 782-8700
GREAT FALLS (406) 761-1674
HELENA (406) 449-5480
KALISPELL (406) 756-1150
MISSOULA (406) 329-3123

HealthShare Montana
Implementation Plan

Phase 1: Requests for Proposals to implement Health Information Exchange with Initial Healthcare Constituents

All interested constituents will apply through a request for proposal process to be the initial implementers of health information exchange. Constituents are hospitals, providers, facilities and departments who are stakeholders of HealthShare Montana with the capacity and interest to implement health information exchange.

Phase 2: Initial Implementation

Five to 10 constituents that consist of some mix of hospital, hospital emergency department, clinic, DPHHS/Medicaid, Indian Health Services, long term care facility, primary care provider with somewhat advanced health information technology capabilities and a provider with no available health information technology will be selected via the RFP process. The implementation plan will be the utilization of the CCR and its contents to ease the transition of care as the patient travels back and forth between the primary care provider, hospital, clinic, nursing home and emergency department.

Functionality – Via the CCR, access to the following:

- Registration information and demographics including insurance information
- Advance directives
- A specific list of current lab values,
- Current medication list
- Record consolidation capability (CCR)

Performance Metrics

- Successful exchange of information across the spectrum of users
- Successful query of patient data and accrual of population data
- Exchanged data elements
- Number of providers participating
- Implementation of disease management
- Development of personal health records

Phase 3: Statewide Rollout

After a year of proof of concept, rollout of the model described above across the entire state of Montana will proceed on an incremental basis where each naturally occurring geographic market area is brought online one a time. Use of existing networks and relationships among healthcare providers will provide the basis for rollout implementation.

HealthShare Montana
Privacy and Security Principles

November 26, 2008

HealthShare Montana (HSM) believes that an individual's health care records should be private and secure. It also believes that patients should have a simple and convenient way to send their records to the health care professionals who treat them. HSM's health information exchange will give patients and their health care professionals the opportunity to share information electronically according to the privacy controls set by the individual patient and their provider. HSM will hold itself to a higher standard for privacy and security protection than under either federal law (known as HIPAA[1]) or Montana state law.

HSM, as the state-wide health information organization, will develop policies and procedures that reflect the privacy and security principles below. These principles seek to: 1) advance each individual's control of and access to their personal health information, 2) allow efficient, secure provision of their personal health information to their chosen health care professionals, and 3) enable opportunities for data driven improvement in the public health of all Montanans.

The following privacy and security principles apply to HSM's collection, use, and disclosure of personal health information.[2]

- **Openness and Transparency.** The governance and administration of HSM will be transparent, including any future changes to this document. Public participation in the process is welcome. Openness about developments, procedures, policies, technology, and practices with respect to the treatment of personal health information is essential to protecting privacy and building trust. Individual patients should be able to understand what information is available about them through HSM, how that information may be used, and how they can exercise reasonable control over that information. This transparency helps promote privacy practices and builds confidence in individuals with regard to information

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[1] Health Insurance Portability and Accountability Act, Public Law 1004-191.

[2] The term "personal health information" or "information" as used in these principles means health information, including demographic information, that relates to the past, present, or future physical or mental health or condition of an individual or to the past present, or future payment for the provision of health care to an individual if there is a reasonable basis to believe the information can be used to identify the individual. This definition includes, but is not limited to, HIPAA "protected health information" (see 45 CFR 160.103, which incorporates the definition of "individually identifiable health information") and such information protected under Montana state law.

privacy, which in turn should increase participation in HSM and other health information exchanges.

- **Participation and Control.** Participation in HSM is voluntary and patients may withdraw at any time. Patients have the right to know what information HSM collects about them, how it is used and who is accessing it. Patients should have control over the distribution of their personal health information. Any exceptions to patient control should be explicit and in accordance with existing public health laws so that each patient can make an informed choice about their participation.

- **Access to Information**. HSM will facilitate, if it is not otherwise available, secure access by individuals to their information stored with or shared through HSM. Individuals will have the ability to designate other people who may have access to their personal health information.

- **Information Collection, Use and Disclosure**. Collection, use, and disclosure of personal health information through HSM, including information for research and public health purposes, will be limited to that which is legally permissible and for a legitimate purpose allowed and disclosed by HSM. HSM will make available upon a patient's request an accounting of all disclosures of personal health information made through HSM.

- **Information Confidentiality, Integrity and Availablity.** HSM will implement reasonable safeguards to protect the privacy and security of any information it receives, maintains or transmits. Any entity that provides personal health information to HSM must also have in place appropriate administrative, technical, and physical safeguards to protect the privacy of that information and to ensure the confidentiality, integrity, and availability of electronic personal health information it creates, receives, maintains, or transmits. HSM will not accept information from any entity unless it is reasonably confident that the entity providing information has implemented policies and procedures that safeguard the information's confidentiality, integrity and availability.

- **Accountability and Oversight.** HSM will establish a mechanism to respond to complaints by individuals of inappropriate or unauthorized access to or use or disclosure of personal health information through HSM. HSM will require that any entity participating in HSM or accessing information through HSM provide privacy and security training to anyone who has access to personal health information through HSM. HSM will conduct periodic audits to ensure appropriate use and disclosure of personal health information and will monitor suspicious activities. HSM may report privacy violations to appropriate government oversight

agencies, and will fully cooperate with any government investigation of breaches of privacy and security laws by HSM or any participating entity or individual.

- **Remedies, including Mitigation.** HSM will exclude any entity from participation in HSM who fails to maintain adequate privacy and security policies and practices. HSM will require participating entities to have and apply appropriate sanctions against any member of its workforce or any business associate who violates HSM's privacy and security policies, and may exclude an entity that fails to adequately implement such disciplinary policies from participation in HSM. HSM may deny access to personal health information to any person HSM reasonably believes has violated HSM's privacy and security expectations. HSM will notify participating entities of any security breach or privacy violation by HSM or its agents related to information provided by that participating entity, and will cooperate fully with the participating entity in notifying individuals affected by the breach to the extent doing so is reasonable and necessary to remedy any harm. HSM will take steps to mitigate, to the extent practicable, any harmful effect of a use or disclosure of personal health information in violation of its policies and procedures or agreements with participating entities.

HealthShare Montana
January 2009

Health Information Exchange Infrastructure

	Year One	Year Two	Total
Disease Management	$60,000	$60,000	$120,000
Set-Up Imports, Implementation	$30,000	$6,500	$36,500
Interfaces, programming	$15,000	$10,000	$25,000
Interfaces, Maintenance	$12,000	$12,000	$24,000
Disease management clinical support	$18,000	$18,000	$36,000
Electronic prescribing	$36,000	$36,000	$72,000
Personnel Health Record physician link	$50,000	$50,000	$100,000
Participating Site expenses	$150,000	$150,000	$300,000
Central Hardware Platform	$84,000	$84,000	$168,000
Sub Total	***$455,000***	***$426,500***	***$881,500***

Operations

Personnel - Executive Director	$105,000	$110,000	$215,000
Personnel - Assistant Director	$82,000	$83,500	$165,500
Personnel - Administrative Assistant	$25,000	$25,000	$50,000
Travel - Instate (100 days/year)	$25,000	$25,000	$50,000
Travel - National HIT Meetings	$5,000	$5,000	$10,000
Office Equipment/Furniture	$4,000	$4,000	$8,000
Legal Services, Operations/Privacy and Security	$20,000	$20,000	$40,000
Liability Insurance	$20,000	$20,000	$40,000
Internet Services Development/Maintenance	$20,000	$20,000	$40,000
Sub Total	***$306,000***	***$312,500***	***$618,500***
Total	**$761,000**	**$739,000**	**$1,500,000**

Projected Revenue Sources

State Allocation	**$750,000**
Federal Allocation	**$750,000**
Total	**$1,500,000**

Introduction

The State of Vermont, under the leadership of its Governor, Legislature and the bi-partisan Health Care Reform Commission, has established a visionary program called the Blueprint for Health. The Blueprint is guiding a comprehensive and statewide process of transformation designed to reduce the health and economic impact of the most common chronic conditions and focus on their prevention. The state's strong commitment is demonstrated in 2006 statutory codification of the Blueprint as the state's plan for changing health care delivery. Further legislation in 2007 and 2008 strengthened the involvement of private insurance carriers. The annual state budget supports the healthcare transformation process, along with expanded use of health information technology and development of a statewide health information exchange network.

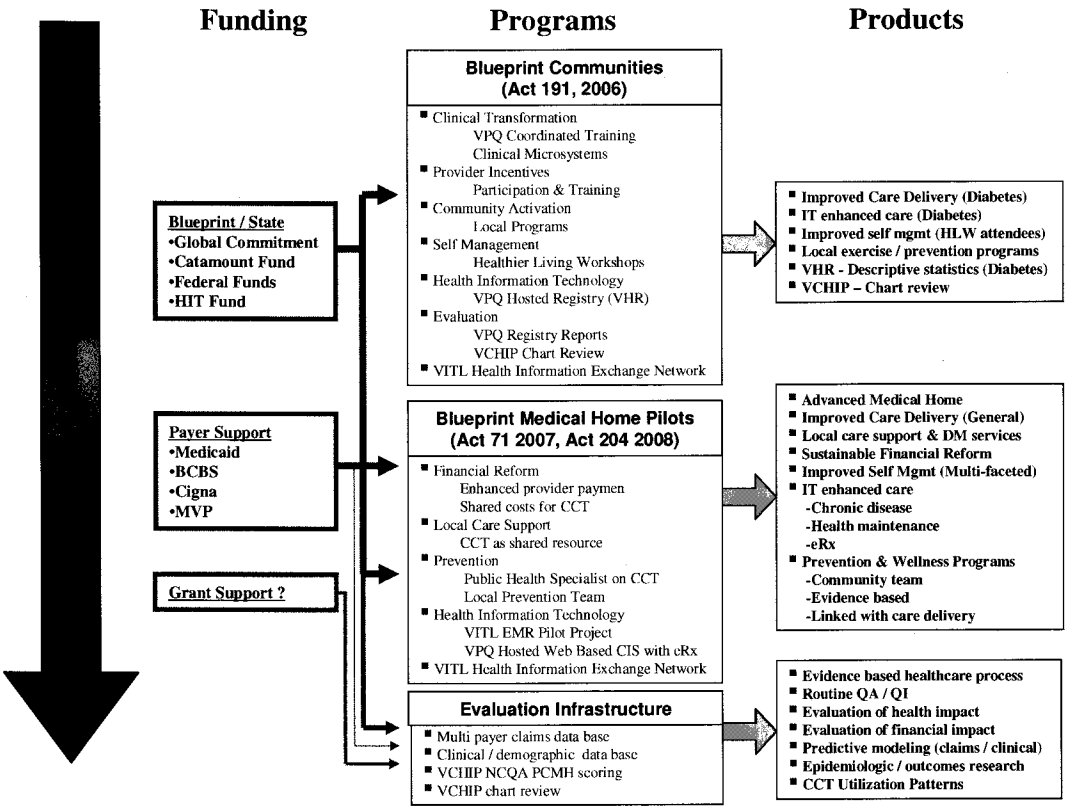
The Blueprint program aims to improve healthcare and prevention for the most prevalent chronic conditions, and thus reduce the negative health and economic impact of poorly controlled disease. Blueprint guided transformation is helping primary care providers operate their practices as patient-centered medical homes, offering well-coordinated care supported by local multidisciplinary teams, expanded use of health information technology, assisting the development of a statewide health information exchange network, and financial reform that sustains these processes and aligns fiscal incentives with healthcare goals. This high level of care incorporates strategies to enhance self management and is closely integrated with community-wide prevention efforts. It is based on a model that is designed to be financially sustainable, scalable, and replicable.

During the last 3 years, 6 Blueprint communities have implemented improved diabetes care and prevention through: provider training and incentives, expanded use of information technology, evidence based process improvement through Clinical Microsystems training, self management workshops (statewide), and support for community activation and prevention programs (statewide).

Starting in 2008, 3 of the Blueprint communities were selected competitively to build on their transformation experience and to implement more comprehensive reform as part of the Blueprint Integrated Pilot Program. Participating practices in each community are provided with the infrastructure and financial incentives to operate a patient centered medical home (PCMH). The pilot practices are provided with enhanced payment based on meeting nationally recognized quality standards, local multidisciplinary care support teams including prevention specialists, a web based clinical tracking system with eRx, and health information exchange. These pilots represent an important step in Vermont's healthcare reform efforts and are intended to result in financially sustainable, high quality, evidence based healthcare and prevention across a community.

The evolution of the Blueprint towards sustainable reform, including guiding legislation and funding sources, is shown below (Figure 1).

Figure 1. Blueprint pathway to sustainable healthcare reform



Blueprint Integrated Pilots

Overview

The Blueprint Integrated Pilot Program (BPIPP) is testing the efficacy and sustainability of multi insurer reform designed to result in effective health care and prevention for a general population. The BPIPP model includes broad transformation of current healthcare financing, clinical operations, public health prevention, and development of a supportive health information environment.

Several novel strategies are being tested in the Blueprint Integrated Pilot Program (BPIPP). First is a public - private approach to multi insurer financial reform that is designed to help practices operate as patient centered medical homes with local care support services. The components of this financial reform include:

- Enhanced provider payment based on a how a practice scores against National Committee on Quality Assurance - Patient Centered Medical Home (NCQA PCMH) standards that is the same for patients insured by a commercial carrier, Vermont Medicaid, and Medicare (subsidized by Blueprint)
- Financial support for local multidisciplinary care support teams (Community Care Teams) that is shared by commercial carriers, Vermont Medicaid and the Blueprint (subsidizing Medicare).

Second is the implementation of Community Care Teams (CCTs) that are intended to assure that each medical home practice, independent of its size, has the local multidisciplinary care support that is essential in order to engage an entire population in effective health maintenance, prevention, and care for chronic disease. The costs for the teams are shared by all insurers establishing a core community resource that can work closely with providers, across practices, offering the services that are necessary for individual patient care and population management.

Third is the implementation of a systematic approach to community prevention that closely integrates the traditionally distinct cultures of public health and healthcare delivery. Each Community Care Team (CCT) will include a Public Health Prevention Specialist based in the local Vermont Department of Health District Office. The Prevention Specialist will work closely with the healthcare delivery members of the CCT, and other key stakeholders in their community to; a) guide structured assessments of the risk factors and conditions that contribute to the prevalence and morbidity from chronic disease, and, b) plan and implement interventions designed to reduce the prevalence and impact of chronic disease.

Fourth is the implementation of an health information environment designed to:

- Support a common level of high quality healthcare for individual patients and populations across different practice settings
- Provide a suite of technical options that meets the variable needs found across these different practice settings.

The major components of the Blueprint Integrated Pilot Model are summarized below.

1. Financial reform
   a. Payment to practices based on NCQA PCMH standards (in addition to current payment)
   b. Shared costs for Community Care Teams
   c. Includes Medicaid & commercial payers
   d. Blueprint subsidizing Medicare portion

2. Community Care Teams (CCTs)
   a. Local multidisciplinary team
   b. Nurse coordinators, medical social workers, behavioral specialists, dieticians, others
   c. Core resource providing care support across practices for prevention, health maintenance and chronic disease
   d. Guideline based care coordination for individuals patients
   e. Guideline based population management

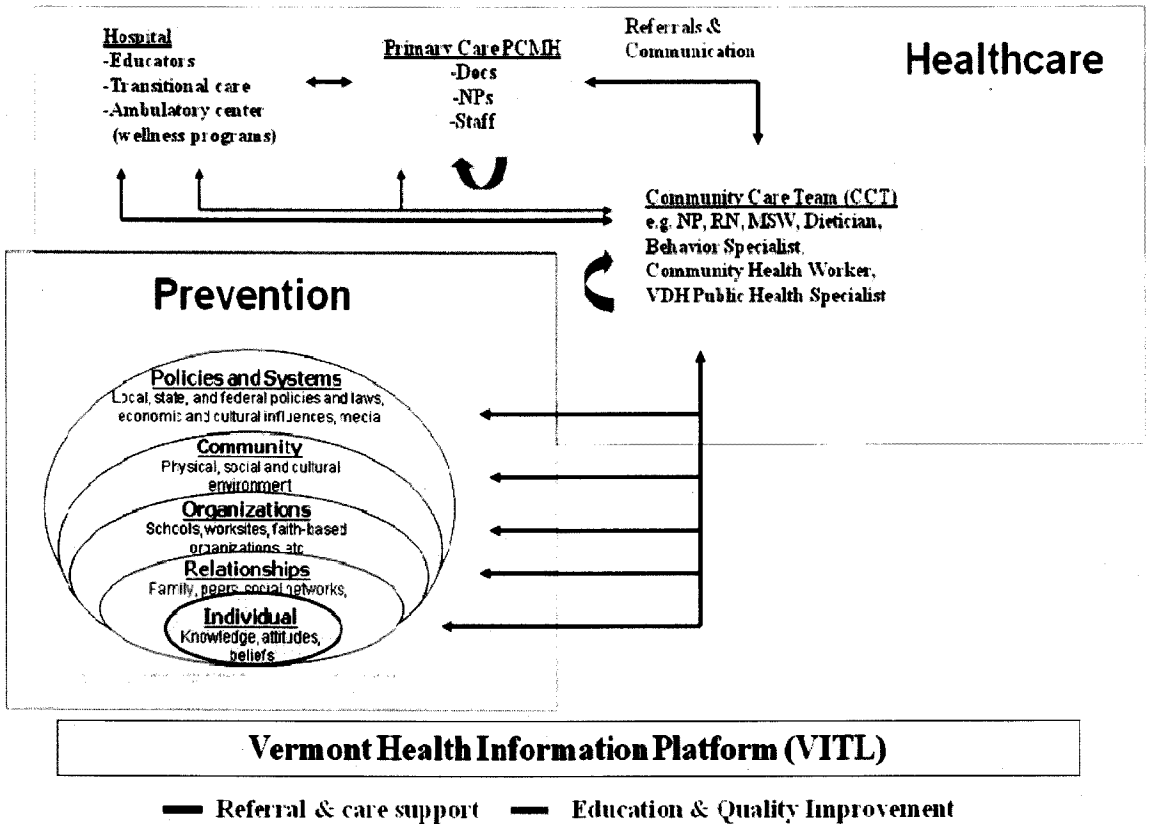
3. Community Activation and Prevention
   a. Public Health Prevention Specialist (PHPS) as part of CCT
   b. Integration of public health prevention and care delivery
   c. PHPS guides a systematic approach to community assessment, broad stakeholder engagement, consensus building, planning, and targeted intervention

4. Health Information Technology
   a. Web based clinical tracking system (DocSite)
   b. DocSite produces visit planners and population reports
   c. Includes electronic prescribing
   d. Electronic Medical Records (EMRs) updated to match program goals and clinical measures in DocSite
   e. Health information exchange network to transmit data between EMRs, hospital data sources, and DocSite

5. Multidimensional Evaluation
   a. NCQA PCMH score (process quality)
   b. Clinical process measures
   c. Health status measures
   d. Claims based healthcare patterns and expenditures (multi insurer data base)
   e. Claims based return on investment and financial impact modeling

Taken together, these components of healthcare reform comprise a model for sustainable, well integrated, care delivery and prevention. The model schematic is displayed below (Figure 2). The following sections discuss each of the major reform components in further detail.

Figure 2. Blueprint model for health and prevention



Financial Reform

The first component of financial reform is the enhanced provider payment for operating as a patient centered medical home. The enhanced provider payment structure that is being tested in the integrated pilot program is intended to align financial incentives with healthcare goals, and to provide practices with the capitol they need to deliver high quality thorough care for their entire patient population. The enhanced payment is based on delivering care in accordance with national quality standards. This is in addition to their normal fee for service reimbursements, with the intent of establishing a balance between quality based payment and volume based payment.

The 9 NCQA PCMH standards include:

- Access and Communication
- Patient tracking and registry functions
- Care management
- Patient self management support
- Electronic prescribing
- Test tracking
- Referral tracking
- Performance reporting and improvement
- Advanced electronic communications.